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IRVING BART, M.D. et al.,

Respondents,

LOUIS W. SULLIVAN,

Secretary of Health and Human Services,

Respondent.

THE STATE OF NEW YORK, et al.,

Petitioners,

LOUIS W. SULLIVAN,

Secretary of Health and Human Services,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

IN SUPPORT OF THE APPLICATION OF
THE PETITIONERS AND SURGEONS
GENERAL FOR A WRIT OF HABEAS CORPUS

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

 No. 89-1391

 IRVING RUST, M.D. *et al.*,
 v. *Petitioners*,

LOUIS W. SULLIVAN,
 Secretary of Health and Human Services,
Respondent.

 No. 89-1392

 THE STATE OF NEW YORK, *et al.*,
 v. *Petitioners*,

LOUIS W. SULLIVAN,
 Secretary of Health and Human Services,
Respondent.

 On Writs of Certiorari to the
 United States Court of Appeals for the Second Circuit

**BRIEF OF THE ASSOCIATION OF
 AMERICAN PHYSICIANS AND SURGEONS
 AS AMICUS CURIAE IN SUPPORT OF RESPONDENT**

INTEREST OF THE AMICUS CURIAE¹

The Association of American Physicians and Surgeons, Inc. (AAPS), a not-for-profit corporation, is the largest association of private practicing physicians in the United

¹ This brief is filed with the written consent of the parties. Letters of consent have been filed with the Clerk of this Court.

States. AAPS is comprised of active, practicing physicians and osteopaths of all specialties, from every state and territory in the United States and the District of Columbia. One purpose of the AAPS is to protect and preserve the integrity of the private practice of medicine and the ethical standards which define the profession. For these reasons, the issues involved in this case are of acute interest to the Association.

SUMMARY OF ARGUMENT

The regulations promulgated by the Secretary under Title X promote the highest standards of medical ethics and medical practice by fostering the health of both the mother and her unborn child. Since neither elective abortion nor prenatal care can be provided in the Title X program, a woman diagnosed as pregnant must be referred beyond the Title X facility for any further treatment of that pregnancy. In referring pregnant women for prenatal care, these regulations are well within the Government's prerogative to advance this traditional medical ethic in public health care services through the allocation of its resources. *Harris v. McRae*, 448 U.S. 297 (1980).

Prenatal care is a preeminent need for every mother and unborn child. These regulations provide for referral care for all women, including the 95% of abortion cases in which the mother's health is in no way implicated. For the five percent of pregnancies in which abortion may be related to the mother's health, these regulations promote considered consultation with a physician who can assess the risks to mother and child and advise appropriate care. The regulations comport with medical ethics by permitting a physician in a Title X project to refer for further medical services any patient who might need services not subsidized under Title X and by providing for the emergency medical needs of patients as these might arise.

The regulations are completely consistent with the doctrine of informed consent. Indeed, they enhance informed consent by requiring the physician to inform the patient upfront of the limits of the subsidized services. Generally, a physician has no ethical or legal obligation to counsel and refer for an elective procedure which he neither provides nor holds himself out to the community as providing. It is the physician proposing the treatment who must obtain informed consent. More specifically, physicians have no ethical obligation to counsel or refer for elective abortion.

Ultimately, the controversy surrounding these regulations, and the need for this Court to review them, is a direct result of *Roe v. Wade*, 410 U.S. 113 (1973). Though couched in terms of "good medicine," Petitioners' challenge necessarily relies on an absolute, autonomous right to elective abortion belonging to the physician and pregnant woman. This is an abortion case, not a First Amendment case. To the extent that Petitioners' claim is that the regulations impose a "content-based" discrimination under the First Amendment, the "content" is nothing more than encouraging elective abortion. This claim requires an expansion of *Roe v. Wade* in two discrete ways. First, Petitioners contend that they have a constitutional right to give abortion information which trumps these regulations. But the *Roe* abortion right belongs entirely to woman, not the physician. *Harris v. McRae*, 448 U.S. 297 (1980); *Whalen v. Roe*, 429 U.S. 589 (1977). Second, Petitioners advance a constitutional right to receive abortion information at government expense. But this Court has repeatedly held that the pregnant woman has no "constitutional entitlement to the financial resources to avail herself of the full range of protected choices." *Harris v. McRae*, 448 U.S. 297, 316 (1980).

Finally, in addition to the legal confusion *Roe* engendered, *Roe* turned traditional medical ethics on its head,

giving rise to a new "model" of medical ethics urged on this Court by Petitioners: that the legal right to abortion on demand requires physicians to ignore their ethical duty to their second patient, the unborn child, and to treat abortion and prenatal care as equally desirable options. By invalidating these regulations, this Court would impose this ethic on all governmental programs and even, by implication, on physicians throughout the land. Such an expansion of *Roe v. Wade* would sow further legal and ethical confusion, contradicts the unambiguous will of Congress that Title X funds not be used "in programs where abortion is a method of family planning," and is not justified by anything in the Constitution.

ARGUMENT

I. INTRODUCTION

Title X of the Public Health Service Act is the national family planning program, which provides annual funding of approximately \$150 million to public and private agencies for "pregnancy prevention." 42 U.S.C. 300 (1982). Section 1008 of Title X provides: "None of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning." 42 U.S.C. 300a-6 (1982).

This appeal involves a facial challenge to regulations adopted by the Secretary of Health and Human Services ("the Secretary") to enforce this critical aspect of Title X. 53 Fed. Reg. 2922 (Feb. 2, 1988) ("the regulations"); 52 Fed. Reg. 33210 (Sept. 1, 1987)). The regulations state that a Title X project "may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning." 42 C.F.R. 59.8(a)(1) (1989). Because the purpose of Title X is to promote contraception and pre-pregnancy family planning, a client diagnosed as pregnant "must be referred for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of

mother and unborn child." 59.8(a)(2). To further protect maternal and fetal well-being, the pregnant woman must also be provided with any information "necessary to protect the health of mother and unborn child until such time as the referral appointment is kept." 59.8(2). In instances of medical emergency, the regulations require the Title X grantee to refer the client "immediately to an appropriate provider of emergency medical services." *Id.* Information medically necessary to assess the risks and benefits of contraceptive methods is also permitted. 59.8(a)(4).

These regulations require the Title X physician to provide accurate, relevant information. The physician is to inform the woman of her current condition. If she is pregnant, she is given a list of prenatal care providers from whom she may choose for referral. The regulations require the physician to be candid in stating that pregnancy care of any kind—prenatal care and abortion—is not a Title X service, and that abortion counseling and referral will not be provided. The only information Title X projects do not provide—that concerning pregnancy treatment options—is available upon referral from the most appropriate supplier of such information, the physician who will deliver the treatment.

The Title X client, like any patient, is free to refuse the referral or the prenatal care after referral. If she refuses the referral, she is left, like any patient, to rely on the private marketplace and on consultation with family or friends to find, if she desires, an abortion. If she accepts the referral (and the required "information necessary to protect the health of the mother and unborn child until such time as the referral appointment is kept"), she may then refuse prenatal care, but she will have had the benefit of counseling and health care for her and her child.

Unmasked, Petitioners' claim is that "good medicine" requires direct, immediate referral for elective abortion without presentation of available alternatives from a

prenatal care provider. With this, we profoundly and strenuously disagree. It is a policy in striking contrast to centuries of medical ethics and harmful to both patients presented in a pregnancy. These regulations present a positive alternative for pregnant Title X clients—many of whom are poor and minority—who may never know the alternatives that may be available in giving birth to their child. See Appendix B (Affidavit of Richard T.F. Schmidt, M.D., FACOG).²

II. THESE REGULATIONS EMBODY THE HIGHEST STANDARDS OF MEDICAL ETHICS BY PROMOTING THE HEALTH OF MOTHER AND CHILD.

Every word and every act by all who come in contact with the pregnant woman should impress upon her both the importance and the availability of prenatal care for her fetus and herself. All too often, especially in public clinics, the strong impression has been propagated that such care is not really available without great expenditure of physical and emotional effort by her, and, too often, of money beyond her ability to pay.³

A. Prenatal Care is a Preeminent Need for Every Mother and Child.

Prenatal medicine is premised on the longstanding ethical principle that the obstetrician has a duty to promote the health and well-being of two patients, mother and unborn child.⁴ Consistent with the Hippocratic ethic

² Steinberg, *Abortion Counseling: To Benefit Maternal Health*, 15 Am. J. Law & Med. 483 (1989); E.V. Mech, *Orientations of Pregnancy Counselors Toward Adoption*, Report prepared for the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services, Grant #APR 000902 (1984).

³ Pritchard, MacDonald & Gant, *Williams Obstetrics* 246 (17th ed. 1985).

⁴ We use the terms "fetus" and "unborn child" interchangeably throughout this brief because law, medicine, and medical jurisprudence have traditionally used both terms to refer to the unborn

of "doing no harm" to one's patients, prenatal care does not pit mother and fetus in an adversarial relationship with competing interests, but, rather strives to serve the health interests of each patient. The most recent edition of *Williams Obstetrics* states unequivocally that obstetricians "must be concerned simultaneously with the lives and well-being of two persons, indeed, the lives of two who are interwoven."⁵

Prenatal care has long been recognized as critical to protecting maternal and fetal health.⁶ For centuries, physicians have understood that a woman's care, behavior, and health during pregnancy affected her unborn child.⁷ The American College of Obstetricians and Gynecologists instructs that "[e]very woman should have a comprehensive program of antepartum care that begins

human without regard to the time of gestation. See e.g., *Evans v. People*, 49 N.Y. 86, 90 (1872); *Hall v. Hancock*, 32 Mass. (15 Pick.) 255, 256 (1834); T. Denman, *An Introduction to the Practice of Midwifery* 287 (3d ed. 1829); 1 W. Blackstone, *Commentaries on the Laws of England* 129 (U. Chicago Reprint 1979); 2 H. Richardson & G. Sayles, *Fleta* 60-61 (Seldon Society ed. 1955) ("a quickened child in her womb"); Ruth, *The Effect of Opium on the Unborn Child*, 10 J.A.M.A. 293 (1888).

⁵ Cunningham, MacDonald & Gant, *Williams Obstetrics* vii (18th ed. 1989).

⁶ See Generally, D. Danforth & J. Scott, *Obstetrics and Gynecology* 5 (5th ed. 1986); H. Speert, *Obstetrics and Gynecology in America: A History*, 142-143 (A.C.O.G. 1980). Direct therapy for unborn infants appeared as far back as 1928, when transabdominal application of drugs for fetal asphyxia was introduced. Dudenhausen, *Historical and ethical aspects of direct treatment of the fetus*, 12 J. Perinatal Med. 17 (1984 Supp.).

⁷ See generally, Hemminki, *Content of Prenatal Care in the United States*, 26 Med. Care 199 (1988); Taussig, *The Story of Prenatal Care*, 34 Am. J. Ob. Gyn. 731 (1937). American prenatal care originated in Boston, led by Charles Green of Harvard's Department of Obstetrics in 1891. Two decades later, J. Whitridge Williams (i.e., *Williams Obstetrics*) became an ardent supporter of systematic prenatal care. Speert, *Obstetrics and Gynecology in America: A History* at 142-43.

as early in the first trimester of pregnancy as is possible."⁸

As understanding of the maternal-fetal relationship has evolved, so has prenatal care. Recent research demonstrating the risk of fetal harm posed by otherwise routine behavior, such as maternal smoking, tobacco chewing, alcohol use, carbon-monoxide exposure, coffee consumption, heavy work, and sexual intercourse highlights the vital importance of early prenatal care.⁹ The scope of prenatal care recommended from early in pregnancy has expanded to encompass health assessment, medical services, social services, nutritional services, patient education, and psychological support. Ryan, et al., *Prenatal care and pregnancy outcome*, 137 Am. J. Ob. Gyn. 876 (1980).¹⁰ Numerous studies document that proper prenatal care decreases likelihood of prematurity and fetal or neonatal mortality,¹¹ while inadequate pre-

⁸ American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 9 (5th ed. 1982).

⁹ Socol, et al., *Maternal smoking causes fetal hypoxia: Experimental evidence*, 142 Am. J. Ob. Gyn. 214 (1982); Krishna, *Tobacco Chewing in Pregnancy*, 85 Brit. J. Ob. Gyn. 726 (1978); Streissguth, et al., *IQ at age 4 in Relation to Maternal Alcohol Use and Smoking During Pregnancy*, 25 Develop. Psych. 3 (1989); Astrup, et al., *Effect of moderate carbon-monoxide exposure on fetal development*, II:7789 Lancet 1220 (1972); Kurppa, et al., *Coffee Consumption during Pregnancy and Selected Congenital Malformations; a nationwide case-control study*, 73 Am. J. Pub. Health 1397 (1983); Manshande, et al., *Rest versus heavy work during the last weeks of pregnancy: influence on fetal growth*, 94 Br. J. Ob. Gyn. 1059 (1987); Grudzinskas, et al., *Does sexual intercourse cause fetal distress?*, II:8144 Lancet 692 (Sept. 29, 1979).

¹⁰ See also Fingerhut, et al., *Delayed Prenatal Care and Place of First Visit; Differences by Health Insurance and Education*, 19 Fam. Plan. Persp. 212 (1987).

¹¹ Hemminki, et al., *Patterns of Prenatal Care in the United States*, 8 J. Pub. Health Pol. 330 (1987); Moore, et al., *The perinatal and economic impact of prenatal care in a low-socioeconomic population*, 154 Am. J. Ob. Gyn. 29 (1986); Ryan, et al., *Prenatal care and pregnancy outcome*, 137 Am. J. Ob. Gyn. 876 (1980).

natal care increases the likelihood of maternal and fetal morbidity.¹²

Prenatal care has proven to be a cost-effective treatment for a significant national health concern. Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* (1988). Early and adequate prenatal care results in healthier newborns. One dollar spent on prenatal care may reduce the costs of postnatal care by three dollars;¹³ a savings of approximately \$2,100 per patient in 1986.¹⁴ Yet, adequate prenatal care services are either unavailable or inaccessible to a needy segment of our population. In 1985, only 68 percent of all preg-

¹² Moore, et al., *The perinatal and economic impact of prenatal care in a low-socioeconomic population*, 154 Am. J. Ob. Gyn. 29 (1986) (significantly greater neonate morbidity for women without prenatal care versus women who received prenatal care); Ryan, et al., *Prenatal care and pregnancy outcome*, 137 Am. J. Ob. Gyn. 876 (1980) ("the group with inadequate prenatal care had significantly higher fetal, neonatal, and perinatal mortality rates." "It is clear that the presence or absence of early and adequate prenatal care is strongly related to pregnancy outcome"); Tokuhata, et al., *Prenatal Care and Obstetric Abnormalities*, 76 J. Chron. Dis. 163 (1973) (prematurity rate of 6.9% with prenatal care versus 23.6% without prenatal care; 1155 congenital anomalies out of 100,000 births for those with prenatal care versus 1622 anomalies for those without prenatal care; 8365 pregnancy complications out of 100,000 births with prenatal care compared to 16,298 complications with no prenatal care).

¹³ McGoldrick, *Prenatal care; Investing in the Future*, 45 J. Am. Med. Women's Assoc. 35 (1990); see also Brown, *Drawing Women into Prenatal Care*, 21 Fam. Plan. Persp. 73 (1989).

¹⁴ Moore, 154 Am. J. Ob. Gyn. at 32. The U.S. Office of Technology Assessment reported that "for every low-birth-weight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between \$14,000 and \$30,000 in newborn hospitalization, rehospitalizations in the first year, and long-term health care costs associated with low birth weight." U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future* 9 (1988).

nant women received adequate prenatal care.¹⁵ Twenty percent of pregnant teenagers and ten percent of all black women obtain little or no prenatal care.¹⁶ "Women who are less educated are less likely to get adequate prenatal care, and [] potential program recipients identify lack of knowledge about where to go for care as an important impediment to seeking out services." Miller et al., *Barriers to Implementation of a Prenatal Care Program for Low Income Women*, 79 Am. J. Pub. Health 62, 63 (1989). Providing adequate and prompt information regarding prenatal care resources is especially important for women with unplanned pregnancies who often delay seeking prenatal care because of negative views of the pregnancy. Brown, *Drawing Women into Prenatal Care*, 21 Fam. Plan. Persp. at 76. Methods of improving access to services include: "Improving institutional practices to make services more easily accessible and acceptable to clients; [a]ttracting women in need of prenatal care through a wide variety of casefinding methods, including . . . cross-agency referrals and the provision of incentives . . . [p]roviding social support to encourage continuation in prenatal care." *Id.* at 78.

Title X clinics can play an important role in removing the informational gap that stands as an obstacle between pregnant women and available prenatal care. By requiring direct referral for prenatal care, the Title X regulations can materially advance maternal and fetal health among those in greatest need of such assistance—the poor, minority women, and teenagers. As a link between pregnant women and networks of community organizations, physicians, and social service agencies, such

¹⁵ Brown, *Drawing women into prenatal care*, 21 Fam. Plan. Persp. 73, 74 (1989).

¹⁶ McGoldrick, 45 J. Am. Med. Women's Assoc. at 35. See also Witwer, *Prenatal Care in the United States; Reports Call for Improvements in Quality and Accessibility*, 22 Fam. Plan. Persp. 31 (1990).

referral can contribute to decreased maternal mortality, infant mortality, and low birth weight. In this way, the challenged regulations are consistent with the highest standards of medical ethics.

B. These Regulations Will Not Cause Unnecessary Delay In Obtaining Appropriate Medical Care.

Despite the obvious benefit of such a prenatal referral network, Petitioners' challenge heavily relies on the speculation that the regulations "may" increase health risks for women and teenagers ("young women may be deterred," "teenagers, may run away from home. . . .") Brief of Petitioner, Rust (Pet. Br.) at 8 n.18.¹⁷ It is impossible to specifically verify or refute this claim, because, as the lower courts recognized, there is no record of enforcement or experience in implementing the regulations. *State of New York v. Sullivan*, 889 F.2d 401, 414 (2d Cir. 1989). See also *Commonwealth of Massachusetts v. Secretary of Health and Human Services*, 873 F.2d 1528, 1553-54 n.11, 12 (1st Cir. 1989) (Torruella, J., concurring in part, dissenting in part). However, Petitioners' hypothetical worst case scenario is wholly inadequate to invalidate these regulations. As recently as *Ohio v. Akron Center for Reproductive Health*, 110 S. Ct. 2972 (1990), this Court rejected such a facial challenge for failing to show that "no set of circumstances exists under which the Act would be valid." 110 S. Ct. at 2980-

¹⁷ The claimed result of these regulations is identical to the claimed result of the Hyde Amendment in *Harris v. McRae*, 448 U.S. 297 (1980). But the claimed results of the Hyde Amendment were found to be highly unreliable. Cf. Petitti & Cates, *Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age*, 67 Am. J. Pub. Health 860 (1977) (predicting up to 90 deaths annually if publicly funded abortions were restricted by the Hyde Amendment) with Gold & Cates, *Restrictions of Federal Funds for Abortion: 18 Months Later*, 69 Am. Pub. Health 929, 929 (1979) (finding three deaths "associated to some degree" with the funding restriction).

81 (quoting *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3060 (O'Connor, J., concurring)).

Nevertheless, Petitioners' contention that the regulations pose significant health risks to pregnant patients ignores several facts. First, it flies in the face of the express requirement that all pregnant Title X patients be referred directly for appropriate prenatal care. Second, Title X is neither intended, nor set-up, to treat the pregnant woman, regardless of what her eventual "treatment" might be. Therefore, a referral is inevitably involved. 53 Fed.Reg. at 2937. Nonetheless, by referring the woman directly to a health care provider who can treat the client's comprehensive medical needs, delays caused by difficulty in locating a prenatal care provider will be lessened.

Third, upon diagnosis of pregnancy, Title X projects must provide information that will "protect maternal and fetal health until a provider of prenatal care is secured for the client." 53 Fed.Reg. at 2937. Thus, the woman is not "pushed out the door" and "forced to fend for herself" in finding a prenatal care provider, as Petitioners suggest. Pet. Br. at 8 n.18. The project also provides the woman with information about good health practices during pregnancy. 59.8(a)(2).

Fourth, women often delay obtaining abortions for reasons totally unrelated to these regulations. According to a study performed by the Alan Guttmacher Institute, affiliated with Planned Parenthood, 71% of women who have abortions at 16 or more weeks gestation, "attributed their delay to not having realized they were pregnant or not having known soon enough the actual gestation of their pregnancy." Torres & Forrest, *Why Do Women Have Abortions?*, 20 Fam. Plan. Persp. 169 (July/August 1988). Petitioners simply ignore the complexity of the reasons why women delay seeking abortion.

More telling is Petitioners' refusal to recognize that nearly every action contributing to an informed decision

will cause "delay." To condemn the decision-making process as causing an unwelcome "delay" belittles the profound nature of the pregnant woman's situation. In fact, physician involvement itself has been "associated with both conflict and delayed abortion." Rosen, *The Patient's View of the Role of the Primary Care Physician in Abortion*, 67 Am. J. Pub. Health 863, 864 (1977).¹⁸

Of course, none of Petitioners' arguments regarding "delay" is balanced against the almost certain death to the unborn child caused by abortion. But Government has a "compelling interest" in the life of the unborn child "throughout pregnancy," which the Government may protect in its funded programs. *Webster; Harris*. Petitioners also fail to question the potential for psychological sequelae from abortion,¹⁹ or the pattern of men coercing women to obtain elective abortions and how this might be compounded by immediate, direct referral for elective abortion.²⁰ Nor do Petitioners question the possible relationship between a practice of immediate, direct referral for election abortion and the rate of repeat abortion which

¹⁸ Cf. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 473 (1983) (O'Connor, J., dissenting): "It is certainly difficult to understand how the Court believes that the physician-patient relationship is able to accommodate any interest that the State has in maternal physical and mental well-being in light of the fact that the record in this case shows that the relationship is nonexistent." See also, D. Reardon, *Aborted Women: Silent No More* (1987).

¹⁹ See e.g., S. Nathanson, *Soul Crisis: One Woman's Journey Through Abortion to Renewal* (1989); McAll & Wilson, *Ritual Mourning for Unresolved Grief After Abortion*, 80 S. Med. J. 817 (1987).

²⁰ See e.g., S. Nathanson, *Soul Crisis* (1989); A. Shostak & G. McLouth, *Men and Abortion: Lessons, Losses and Love* (1984). A study of 81 women at the Medical College of Ohio found that more than one-third felt that they had been coerced into their decision for abortion. Franco, et al., *Psychological Profile of Dysphoric Women Postabortion*, 44 J. Am. Med. Women's Assoc. 113 (1989).

has climbed to 42.9%. Henshaw, et al., *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients*, 20 Fam. Plan. Persp. 158, 159 (1988) (Table 1).²¹

The regulations require prompt referral for prenatal care, the essence of which is to address any health dangers a pregnancy poses to the pregnant woman and her child. Rather than "pos[ing] serious health dangers," referral under the regulations may ameliorate conditions needing medical attention. To claim that these regulations leave pregnant women with "no other source of medical advice" is most disingenuous when the regulations require direct referral to non-Title X medical personnel. And the claim that these regulations fail to meet the medical needs of pregnant women with serious medical conditions who "need" abortion ignores completely the reality that approximately 95% of the 1.5 million abortions performed annually in the United States are elective and have no relation to the health needs of the women.²² The claim of Petitioners and their *amici* that these regulations "pose serious health dangers to patients," then, is nothing more than a counter policy judgment: elective abortion is better than childbirth. But this

²¹ To the extent that Petitioners argue that these regulations will have an impact on access to abortion, they support the Secretary's claim that current Title X practices "encourage" or "promote" abortion as a method of family planning in contravention of Congressional intent. J.A. 37, 56-57.

²² Approximately "two percent of all abortions in this country are done for some clinically identifiable entity—physical health problem, amniocentesis, and identified genetic disease or something of that kind." The remainder are elective, "performed on women who for various reasons do not wish to be pregnant at this time." *Constitutional Amendments Relating to Abortion: Hearings on S.J. Res. 17, S.J. Res. 18, S.J. Res. 19, and S.J. Res. 10 Before the Subcommittee on the Constitution of the Senate Committee on the Judiciary*, 97th Cong., 1st Sess. 158 (1981) (statement of Irvin M. Cushner, M.D., M.P.H., U.C.L.A. School of Public Health); see also Torres & Forrest, *Why Do Women Have Abortions?*, 20 Fam. Plan. Persp. 169 (1988).

is not a policy that Congress or the Secretary need adopt in public programs.²³

C. The Same Ethical Standards Embodied In the Regulations Were Relied Upon by the Sponsors of Title X In Establishing the Abortion Prohibition in Section 1008.

Section 1008 of Title X expresses a clear policy preference favoring childbirth over abortion. This Court has repeatedly affirmed that such a preference is within the constitutional prerogatives of Congress and may be reflected in its funding of federal programs. *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464, 478 & n.11 (1977). Rep. John Dingell (D. Mich.), the sponsor of section 1008, articulated this same preference:

During the course of House hearings on H.R. 19318 there was some confusion regarding the nature of the family planning programs envisioned, whether or not they extended to include abortion as a method of family planning. With the "prohibition of abortion" amendment—Title X, section 1008—the committee members clearly intend that *abortion is not to be encouraged or promoted in any way through this legislation*. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act.

Several considerations prompt this action.

There is a fundamental difference between the prevention of conception and the destruction of developing human life. Responsible parenthood requires different attitudes toward human life once conceived than toward the employment of preventive contraception devices or methods. What is unplanned contraceptively does not necessarily become unwanted humanly. Whether a conceived child is

²³ For a fuller refutation of Petitioners' argument, see *Brief of Feminists for Life of America, et al., as Amici Curiae in Support of Respondent*.

loved or unloved is dependent on factors that, at best, can only be marginally related to family planning.

116 Cong.Rec. 37365, 37375 (1970) (emphasis supplied). Rep. Dingell supported this distinction between pre-conception family planning and abortion by citing medical and legal texts that discussed the nature and rights of the unborn child. *Id.* at 37365-79. This clear statement of purpose should guide this Court's inquiry, as "[i]t is the sponsors that we look to when the meaning of the statutory words is in doubt." *Schwegmann Bros. v. Calvert Distillers Corp.*, 341 U.S. 384, 394-95 (1951). See also *id.* at 399-400 (Frankfurter, J., dissenting). The Secretary's policy, then, is consistent with medicine and the purposes of Congress.

III. PHYSICIANS HAVE NO ETHICAL OBLIGATION TO COUNSEL OR REFER FOR ELECTIVE ABORTION.

A. The Physician Has a Traditional Ethical Duty to Promote the Health of His Two Patients, the Mother and Unborn Child.

Medicine's traditional endorsement of prenatal care for mother and child operates on the premise that the obstetrician should promote the health of two patients: the mother and unborn child. This goal of prenatal care conforms to the Hippocratic tradition of "doing no harm" to one's patients. Counseling and referral for elective abortion directly violates traditional medical ethics by utterly ignoring the ethical obligation that the physician has to his second patient, the unborn child. These regulations are thus superior to Petitioners' scheme in meeting the highest standards of medical ethics.

Perhaps the most important principle of medical ethics is the physician's obligation to promote the life and health of his patient. Traditional American medical ethics have always treated the unborn child as a patient,

although the degree to which medicine could treat that patient has always been dependent on the development of medical science.²⁴ Contemporary medical ethics reaffirms the unborn child as a distinct patient.²⁵ "Indeed, the fetus is no longer dealt with as a maternal appendage

²⁴ "[T]he health of the fetus has always been a concern. . . . In some obvious nontechnical senses, the fetus has always been regarded as a patient." Shinn, "The Fetus As Patient: A Philosophical and Ethical Perspective," in Milunsky & Annas, eds., *Genetics and the Law III* 318 (1985). See also Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 Ob. & Gyn. 209, 213 (1981). "Prior to recent developments in fetal surgery, the fetus generally was considered a medical patient and certain defects were treated with medicines administered to the mother or directly into the amniotic fluid." Blank, *Emerging Notions of Women's Rights and Responsibilities During Gestation*, 7 J. Legal. Med. 441, 461 (1986).

²⁵ See generally K. Maeda, ed., *The Fetus As A Patient '87: Proceedings of the Third Inter'l Symposium* (1987); A. Kurjak, ed., *The Fetus as a Patient, Proceedings of the First International Symposium* (1985); M. Harrison, et al., *The Unborn Patient: Prenatal Diagnosis and Treatment* (1984); E. Volpe, *Patient in the Womb* (1984); Manning, *Reflections on Future Directions of Perinatal Medicine*, 13 Sem. Perin. 342 (1989); Mahoney, *Editorial: The Fetus as Patient*, 150 West. J. Med. 459 (1989); Newton, *The Fetus as a Patient*, 73 Med. Clin. N. Amer. 517 (1989); Rosner, et al., *Fetal therapy and surgery: Fetal rights versus maternal obligations*, 89 N.Y. State J. Med. 80 (1989); Brodner, et al., *Fetal Therapy: Ethical and Legal Implications of Prenatal Intervention and Clinical Application*, 2 Fetal Ther. 57, 58 (1987); Chervenak, et al., *Ethical Analysis of the intrapartum management of pregnancy complicated by fetal hydrocephalus and macrocephaly*, 68 Obst. & Gyn. 720 (Nov. 1986); Chervenak & McCullough, *Perinatal ethics: a practical method of analysis of obligations to mother and fetus*, 66 Obst. & Gyn. 442 (1985); Shinn, "The fetus as patient," in Milunsky & Annas, eds., *Genetics and the Law III* 317-329 (1985); Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 Am. J. Law & Med. 1 (1983); Gilmore, *Is the fetus a patient?*, 128 Can. Med. Assoc. J. 1472 (1983); Harrison, *Unborn: Historical perspective of the fetus as a patient*, 45 The Pharos 19 (1982); P. Ramsey, "Screening: An Ethicist's View," in B. Hilton, et al., *Ethical Issues in Human Genetics* (1973).

ultimately to be shed at the whim of biologic forces beyond control. Instead, the fetus has achieved the status of the second patient, a patient who usually faces much greater risks of serious morbidity and mortality than does the mother." Pritchard, MacDonald & Gant, *Williams Obstetrics* 267 (17th ed. 1985). "[T]he status of the fetus has been elevated to that of a patient who should be given the same meticulous care by the physician that we long have given the pregnant woman." *Id.* at 139.

Such traditional principles of medical ethics are reinforced by new advances in medical technology. New fetal visualizing and diagnostic techniques such as sonography—now routine in the fifteenth or sixteenth week of pregnancy—have had a tremendous impact in altering society's perception of the once "hidden" fetus. Parents are now able to see their children, with detailed, individual facial features and movements months before birth.²⁶ *In utero* treatments have been performed successfully for hydrocephalus, hydrops fetalis associated with maternal Rh sensitization, congenital adrenal hyperplasia, urinary tract malformation, congenital hydronephrosis, perinatal asphyxia, and congenital cystic adenomatoid malformation.²⁷ Intrauterine blood transfusions also have been

²⁶ "The more that parents actually see the fetus and recognize a human form, the more valuable will that fetus become in their eyes. . . . [S]ince ultrasound is being more routinely used in obstetrical practice and is indicated for many high-risk pregnancies, we have good reason to believe that a more complex and progressively more human relationship will begin to develop between parents and fetuses." Harrison, *The Unborn Patient* at 165.

²⁷ Frigoletto, et al., *Antenatal Treatment of Hydrocephalus by Ventriculoamniotic Shunting*, 248 J.A.M.A. 2496 (1982); McCullough, *A History of the Treatment of hydrocephalus*, 1 Fetal Ther. 38 (1986); Editorial, *Prenatal Treatment of Congenital Adrenal Hyperplasia*, 335 Lancet 510-511 (March 3, 1990); Golbus, et al., *In utero treatment of urinary tract obstruction*, 152 Am. J. Ob. Gyn. 383 (1982); Harrison, et al., *Management of the fetus with a urinary tract Malformation*, 246 J.A.M.A. 635 (1981); Manning,

performed for a variety of fetal diseases.²⁸ Fetal surgery has also been performed by removing the fetus from the uterus, operating, and then replacing the fetus into the uterus.²⁹

Fetal therapy may be conducted nearly throughout pregnancy. Proper control of a diabetic mother's fuel metabolism at six to eight weeks of gestation can prevent fetal malformations. Nelson, *Diabetes and Pregnancy: Control Can Make a Difference*, 61 Mayo Clin. Proc. 825 (1986). Additional therapy available for pre-viable, unborn children in the first trimester include treatments for congenital adrenal hyperplasia, some vitamin-responsive inborn errors of metabolism, neural tube defects, and fetal cardiac arrhythmias.³⁰ As one expert has stated,

et al., *Antepartum chronic fetal vesicoamniotic shunts for obstructive uropathy; a report of two cases*, 145 Am. J. Ob. Gyn. 819 (1983); Vallancien, et al., *Percutaneous Nephrostomy in Utero*, 20 Urology 647 (1982); Harrison, et al., *Fetal surgery for Congenital hydronephrosis*, 306 N. Eng. J. Med. 591 (1982); Kirkinen, et al., *Repeated transabdominal renocenteses in a case of fetal hydronephrotic kidney*, 142 Am. J. Ob. Gyn. 1049 (1982); Jacobs, et al., *Prevention, Recognition, and Treatment of Perinatal Asphyxia*, 16 Clin. Perin. 785 (1989); Nugent, et al., *Prenatal Treatment of Type I Congenital Cystic Adenomatoid Malformation by Intrauterine Fetal Thoracentesis*, 17 J. Clin. Ultra. 675 (1989).

²⁸ Gonsoulin, et al., *Serial Maternal Blood Donations for Intrauterine Transfusion*, 75 Ob. Gyn. 158 (1990); Keckstein, et al., *Intrauterine treatment of severe fetal erythroblastosis: intravascular transfusion with ultrasonic guidance*, 17 J. Perin. Med. 341 (1989); Pattison, et al., *The Management of Severe Erythroblastosis Fetalis by Fetal Transfusion: Survival of Transfused Adult Erythrocytes in the Fetus*, 74 Ob. Gyn. 901 (1989); Peters, et al., *Cordocentesis for the Diagnosis and Treatment of Human Fetal Parvovirus infection*, 75 Ob. & Gyn. 501 (1990); Pringle, *Fetal surgery: It has a Past, Has it a Future?* 1 Fetal Ther. 25 (1986).

²⁹ See e.g., Harrison, et al., *Successful Repair in Utero of a Fetal Diaphragmatic Hernia after Removal of Herniated Viscera from the Left Thorax*, 332 N. Eng. J. Med. 1582 (1990).

³⁰ Schulman, *Treatment of the Embryo and the Fetus in the First Trimester*, 35 Am. J. Med. Genetics 197 (1990).

speaking in 1980, "the last decade was the decade of prenatal diagnosis, but this decade will be the decade of prenatal therapy—not only prenatal surgery but other medical intervention."³¹ Even though fetal surgery is a relatively new phenomenon, "there exists a likely possibility that prenatal therapeutic interventions will become an accepted standard of medical care."³² As medical treatment has been extended back to the earliest point of *in utero* human life, "one can expect a new level of respect for the previable fetus whose disorders were previously diagnosable but untreatable."³³ Basic prenatal care is necessary for these patients.

B. Counseling and Referral for Elective Abortion Violates the Ethical Obligation that a Physician Has to His Two Patients, the Mother and Child.

The concept of the fetal patient imposes an affirmative duty on the physician. When a physician enters into a relationship with a pregnant woman, that physician establishes duties towards two patients, mother and unborn child. Once the relationship exists, the physician is bound to provide all due care in nurturing the health and life of both patients.

The fetus' patient status flows from the biologically human nature of the fetus, not from maternal consent. Physicians have a moral obligation to the fetal patient apart from the mother's interests. This ethical duty is not eclipsed by the mother's desire for an elective abortion. It is ethically untenable that a physician must abandon his duty to the fetal patient merely upon the mother's desire to be rid of the fetus. Abortion counsel-

³¹ Harrison, et al., *Correction of Congenital Diaphragmatic Hernia in Utero*, 16 J. Ped. Surg. 934, 942 (1981).

³² Lenow, *Prenatal Intervention: Duty v. Liability*, 13 Leg. Aspect. Med. Prac. 1-2 (1985).

³³ Harrison, *The Unborn Patient* at 164.

ing and referral flatly contradict the shared premise of prenatal care and fetal therapy; that is, a medical obligation to the fetus as well as to the mother. Because of this dual obligation, a physician is neither legally nor morally required to provide information about elective abortion to a pregnant patient. Presenting elective abortion as an acceptable "option" jeopardizes the life of a physician's fetal patient. The accepted premises of prenatal care and fetal therapy have reconfirmed that the practice of elective abortion is utterly repugnant to the traditional ethics and goals of medicine.³⁴

IV. PHYSICIANS HAVE NO LEGAL OBLIGATION TO COUNSEL OR REFER FOR ELECTIVE ABORTION.

A. The Doctrine of Informed Consent Does Not Require A Physician to Counsel or Refer for an Elective Treatment That He Neither Provides Nor Holds Himself Out to the Community As Providing.

The Petitioners claim that these regulations prevent Title X clients from receiving complete information and, thus, violate the doctrine of informed consent. This claim ignores both the nature of informed consent and government's traditional authority to regulate the medical profession, including physician-patient communication.

Informed consent doctrine requires that physicians have their patient's "informed consent" before proceeding with medical treatment:

³⁴ "The fetus now begins to make serious claims for a right to nutrition, to protection, to therapy. How can tolerance of abortion be morally reconciled with those claims?" Ruddick & Wilcox, *Operating on the Fetus*, 12 Hast. Cent. Rep. 10, 11 (1982) (quoting Richard McCormick); "The paradox here for the abortion debate is evident: a moral status that is denied the fetus when abortion is sought is given the fetus when its future healthy development is desired, though the same generic organism is under consideration." Callahan, *How Technology is Reframing the Abortion Debate*, 16 Hast. Cent. Rep. 33, 37 (1986).

[T]he doctrine of informed consent arises out of the unquestioned principle that absent extenuating circumstances a patient has the right to exercise control over his or her body by making an informed choice concerning whether to submit to a particular medical procedure. [cit. omit.] Thus, a doctor recommending a particular procedure generally has, among other obligations, the duty to disclose to the patient all material risks involved in the procedure.

Pauscher v. Iowa Methodist Center, 408 N.W.2d 355, 358 (Iowa 1987). An action for violation of informed consent is a form of medical malpractice and thus requires proof of the common law elements of duty, breach, causation, and damage. See e.g., *Prooth v. Wallsh*, 105 Misc.2d 603, 432 N.Y.S.2d 663 (1980). To establish a duty, there must be a physician-patient relationship or an agreement to provide services.³⁵ A duty to inform only arises once the physician has agreed to provide services, has "proposed" treatment, or a physician-patient relationship for those services exists. The physician must "undertake" to provide the service or "prescribe" the service or treatment. *Ferguson v. Wolkin*, 131 Misc.2d 304, 305, 499 N.Y.S.2d 356, 357 (1986); *Nichelson v. Curtis*, 117 Ill. App.3d 100, 452 N.E.2d 883 (1983); *Taber v. Riordan*, 83 Ill.App.3d 900, 403 N.E.2d 1349, 1353 (1980). Informed consent involves a "reasonable disclosure of the available choices with respect to proposed therapy and of the danger inherently and potentially involved in each." *Cobbs v. Grant*, 8 Cal.3d 239, 243, 502 P.2d 1, 10 (1972). However, "it is clearly not necessary that every physician or health care provider who becomes involved with a patient obtain informed consent to every medical

³⁵ *Salzman v. Rosell*, 129 A.D.2d 833, 513 N.Y.S.2d 846 (1987); *United Calender Mfg. Corp. v. Huang*, 94 A.D.2d 176, 463 N.Y.S.2d 497, 500 (1983); *Ferguson v. Wolkin*, 131 Misc.2d 304, 499 N.Y.S.2d 356, 357 (1986); *Prooth v. Wallsh*, 105 Misc.2d 603, 432 N.Y.S.2d 663 (1980).

procedure to which the patient submits. *Rather, it is the responsibility of a physician to obtain informed consent to those procedures and treatments which the physician actually prescribes or performs.*" *Nisenholtz v. Mount Sinai Hospital*, 126 Misc.2d 658, 483 N.Y.S.2d 568, 572 (1984) (emphasis supplied):

Courts in other states appear to have adhered to the rule that a physician's duty to obtain informed consent from a patient arises only when the physician formally orders or actually performs a procedure or conducts a course of treatment. For example, in *Hallay v. Birbiglia*, [cit. omit.], a doctor who examined a child and recommended a test which caused injury to the child, was not held liable because he did not formally order the test . . . In *Berkey v. Anderson* [cit. omit.], the court found that a physician who prescribed a myelogram could be found liable for failing to obtain informed consent when the patient was injured during the performance of the procedure by another physician.

Id. at 572 (emphasis in original). The physician "can only be liable for breach of duty with respect to those functions he was required to undertake." *Ferguson*, 499 N.Y.S.2d at 357. Accordingly, if the physician does not propose a treatment or procedure for the patient's condition because such treatment is beyond that which the physician can or will provide, the physician has no duty to inform the patient concerning the treatment or procedure.

The straightforward application of these basic principles refutes Petitioners' claim that physicians in Title X clinics must provide information about a elective abortion. The regulations require that patients are informed upon inquiry that Title X does not provide abortions or abortion counseling and referral services. Such disclosure bolsters clear physician-patient communication and is consistent with the doctrine of informed consent. The Title X program is neither designed nor funded to treat, but

rather to avert, pregnancy. Treatment of pregnancy is not a Title X service. Therefore, information about such treatment, e.g., abortion, is not a part of the program. As the treatment cannot be provided under Title X, there is no treatment decision to be made, and there can be no obligation on Title X physicians to provide such information. Because the program itself prohibits the treatment, the doctrine of informed consent is not even implicated. The regulations thus complement the 1970 statutory prohibition on the performance of elective abortion by requiring any discussion concerning elective abortion to be conducted at the time and in the location that is most logically and ethically related to the performance of any elective abortion—with the physician who might provide such services. In the same way, the duty to warn the patient of the benefits and burdens (complications, dangers, risks, hazards) of a treatment that the physician is willing and able to perform and is now proposing is simply not involved.

In this way, these implementing regulations will *affirmatively protect* physician from medical malpractice claims. Clients will be apprised that the purpose of Title X is to provide subsidized contraception and pre-pregnancy family planning, and that Congress funds only those services. The regulations exclude from the scope of the program actions by physician relating to abortion that might give rise to a malpractice claim related to pregnancy treatment.

Similarly, Petitioners' contention that these regulations will permit wrongful birth/wrongful life actions against physicians in Title X programs cannot be sustained. These actions, like those for violation of informed consent, require that the physician is in a position to propose, offer, or perform prenatal care, genetic testing, or abortions. See e.g., *Becker v. Schwartz*, 46 N.Y.2d 401 (N.Y. 1978). Such allegations cannot be made against a Title X physician. By providing full and clear information that

Title X programs provide only contraception and pre-pregnancy family planning, these regulations will affirmatively shield physicians in Title X programs from medical malpractice claims based on a failure to counsel or refer for abortion under Title X.³⁶

In addition to ignoring the ethical and practical limitations on informed consent, Petitioners fail to recognize traditional governmental authority to regulate medical practice and *speech* between physician and patient through the regulation of informed consent. This Court has long recognized a state's power to protect the health of its citizens through the exercise of legislative authority, including regulations of the medical profession.³⁷ Many states have enacted informed consent statutes to regulate specific medical, including gynecological, procedures.³⁸ Moreover, states have increased their regulation by requiring the communication of certain, specific information. States are requiring the provision of information of certain specified risks for medical procedures such as breast cancer treatment,³⁹ hysterectomies,⁴⁰

³⁶ Wrongful birth/life claims are a direct result of this Court's decision in *Roe v. Wade*. But several states have abolished these suits by statute. Idaho Code 5-334 (1990); Minn. Stat. Ann. 145.424 (West 1989); S.D. Codified Laws Ann. 21-55-2 (Supp. 1985); Utah Code Ann. 78-11-24 (Supp. 1985). By judicial decision, North Carolina and Missouri have refused to recognize either wrongful birth or wrongful life suits. *Wilson v. Kuenzi*, 751 P.2d 741 (Mo. 1988), *cert. denied*, 109 S.Ct. 229 (1988); *Azzolino v. Dingfelder*, 337 S.E.2d 528 (N.C. 1985), *cert. denied*, 107 S.C. 131 (1986). Most state courts have refused to recognize wrongful life suits. Such statutory or judicial prohibitions are constitutional. *Hickman v. Group Health Plan, Inc.*, 396 N.W.2d 10 (Minn. 1986).

³⁷ *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977); *Barsky v. Board of Regents*, 347 U.S. 442 (1954); *Watson v. Maryland*, 218 U.S. 173, 176 (1910); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889).

³⁸ Statutes set forth in Appendix C.

³⁹ Cal. Health & Safety Code sec. 1704.5 (West Supp. 1990); Fla. Stat. Ann. sec. 458.324, 459.0125 (West Supp. 1990); Ga. Code Ann. sec. 43-34-21 (1988); Haw. Rev. Stat. sec. 67-3(c) (1985);

sterilizations,⁴¹ and AIDS treatment.⁴² California, for example, requires physicians to provide to patients a state-written "standardized written summary which explains the advantages, disadvantages, risks and descriptions of autologous blood and directed and nondirected homologous blood. . . ." Cal. Health & Safety Code 1645. California physicians are also required to provide to patients with breast cancer treatment a state-written summary of the "advantages, disadvantages, risks and descriptions of the procedures with regard to medically viable and efficacious alternative methods of treatment. . . ." Cal. Health & Safety Code 1704.5. The Petitioners may quibble over exactly what these statutes require, but there

Ky. Rev. Stat. 311.935 (Baldwin 1987); Mich. Comp. Laws Ann. 333.17013 (West Supp. 1990-91); Minn. Stat. Ann. 144.651(9) (West 1989); N.J. Rev. Stat. Ann. 45:9-22 (West Supp. 1989-90); N.Y. Pub. Health Law 2404 (McKinney Supp. 1990); Pa. Cons. Stat. Ann. tit. 35, 5641 (Purdon Supp. 1990-91); Va. Code Ann. 54.1-294 (1988).

⁴⁰ 42 C.F.R. 441.250-259 (1989); Cal. Health & Safety Code 1690, 1691 (West Supp. 1990); Md. Health Gen. Code Ann. 19-348 (1990) (hospital in-patients' opportunity to receive papanicolaou smear); Ohio Rev. Code Ann. 3701.60 (Anderson 1988) (hospital in-patients' opportunity to receive uterine cytologic examination).

⁴¹ 42 C.F.R. 441.250-259 (1989); Cal. Wel. & Inst. Code 14191, 14192 (West 1990); Conn. Gen. Stat. ann. 45-78q, -78r (West 1981); Ky. Rev. Stat. Ann. 212.341-347 (Baldwin 1982); Me. Rev. Stat. Ann. tit. 34-B 7003, 7004 (West 1988); Or. Rev. Stat. 436.225-325 (1989); Utah Code Ann. 62A-6-102 (1989); Va. Code Ann. 54.1-2974 (1988).

⁴² Cal. Health & Safety Code 1603.1, 1603.3 (West Supp. 1990); Del. Code Ann. tit. 16, 1201, 1202 (Supp. 1988); Fla. Stat. Ann. 381.609, 381.6105, 641.3007 (West Supp. 1990); Haw. Rev. Stat. 325-16 (Supp. 1989); Ill. Ann. Stat. ch. 111½, para. 7303-7309 (Smith Hurd 1988); Me. Rev. Stat. Ann. tit. 5, 19203-A (1989); Md. Health Gen. Code Ann. 18-336 (1990); Mich. Comp. Laws Ann. 333.5133 (West Supp. 1990-91); Mont. Code Ann. 50-16-1001, 50-16-1007 (1979); N.Y. Pub. Health Law 2781 (McKinney Supp. 1990); N.Y. Ins. Law 2611 (McKinney Supp. 1990); Or. Rev. Stat. 433.045 (1989); R.I. Gen. Laws 23-6-12, 23-6-14 (1989); W. Va. Code 16-3C-2 (Supp. 1989); Wis. Stat. Ann. 144.025 (West 1989).

can be no doubt that the states have traditionally regulated this area.

B. The Legal Standard is that Physicians Need Not Counsel or Refer for Elective Abortion.

In addition to the more general limitations on the doctrine of informed consent, legislation in most states specifically protects the refusal to provide abortion counseling and referral. The law in at least 43 states is that physicians need not perform, suggest, or counsel for abortion.⁴³ Federal law also provides that no grantee of federal funds may "discriminate" against "any physician or other health care personnel . . . because he refused to perform or assist in the performance" of an abortion. 42 U.S.C. 300a-7(b)(1)(B) (1982); J.A. 17, 63-65. Therefore, whether a physician will counsel and refer for abortion as a method of family planning is, as long as *Roe v. Wade* survives, entirely a matter of the personal choice of the physician. It is not a mandatory legal or ethical standard and should not be imposed as a rule of constitutional law by this Court.

V. CONGRESS AND THE ADMINISTRATION MAY PROPERLY DECIDE TO PROMOTE THE TRADITIONAL MODEL OF MEDICAL ETHICS IN FAVOR OF CHILDBIRTH IN A FEDERALLY FUNDED PROGRAM.

Petitioners' charge that physicians have an ethical obligation to counsel and refer for elective abortions which the government must fund in its Title X clinics is yet another attempt to expand *Roe v. Wade*, 410 U.S. 113 (1973). This latest attempt asks the Court to adopt Petitioners' particular ethical model as another chapter

⁴³ Statutes set forth in Appendix D. Of course, 50 states prohibited abortion more tightly before *Roe v. Wade* and at least 15 states banned the advertisement of abortion services and/or abortifacients. See Linton, *Enforcement of State Abortion Statutes After Roe: A State-By-State Analysis*, 67 U.Det. L.R. 157 (1990).

in *Roe*'s medical regulatory framework. However, *Roe* requires no such expansion. Neither does medical ethics.

Roe v. Wade sparked a volatile conflict by imposing, by implication, throughout the country a new ethical model into the relationship between the pregnant woman, her unborn child, and the physician. While medical ethics has traditionally embraced a beneficence model, *Roe* seemed to disregard this standard in the abortion context.⁴⁴ The beneficence principle "requires that one help others further important and legitimate interests and abstain from injuring them."⁴⁵ For centuries the beneficence principle embodied in the Hippocratic Oath has been viewed as "the proper moral end of medicine, and commitment to that end makes one a physician." *Id.* at 29. Straightforward application of the beneficence principle to the fetal patient requires that physicians promote the health of the fetus (as in prenatal care and fetal therapy), and refrain from harming the fetus (as in abortion). By proscribing abortion and counseling for abortion, the Hippocratic Oath allowed no doubt on this point.

In contrast to the beneficence model, the autonomy model "interprets the best interests of the patient exclusively from the perspective of the patient, as he or she understands them. This perspective may sometimes be starkly different from that of medicine."⁴⁶ The physician no longer is duty-bound to do good; but rather is to carry out the client's requests. When the principles of beneficence and autonomy conflict, a delicate balance must be struck. For example, a Jehovah's Witness' autonomy

⁴⁴ "*Roe v. Wade* and the related cases stand almost alone in the law's approach to maternal-fetal conflict. The general trend has been to protect fetal interest, particularly when a live-birth results or is expected." Fost, *Maternal-fetal conflicts: Ethical and Legal Considerations*, 562 Ann. N.Y. Acad. Sci. 248, 250 (1989).

⁴⁵ Beauchamp & McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* 27 (1984).

⁴⁶ *Id.* at 22.

in refusing a self-saving blood transfusion may override the physician's duty to save the patient's life. However, when a pregnant woman requires a blood transfusion and both mother and fetus would die without the treatment, the physician's beneficence duty may override the mother's autonomy.

Elective abortion brings the beneficence and autonomy principles into violent collision. The two principles cannot both be adhered to fully in the abortion context. Either the physician will choose to act consistent with traditional medical ethics and beneficence or he will defer to the autonomy model and carry out the woman's desires, at the expense of the life of the unborn child.

Certain *amici* readily concede that there are two models of informed consent doctrine—an "autonomy" model and a "therapeutic" or beneficence model—and they note that the autonomy model was first adopted in a 1960 state court decision. *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960). Petitioners are asking that this Court incorporate one of these models—the autonomy model—into the First Amendment through *Roe v. Wade* and raise it to constitutional status in order to strike down these regulations. It is clear that Petitioners' model, particularly in the abortion context, is not "deeply rooted in this Nation's history and tradition" and no other rationale is given as to why this model should suddenly be explicitly imposed on the country as part of the First Amendment. *Cf. Webster; Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).⁴⁷

The principle of beneficence, however, has been integral to medical ethics since the Hippocratic Oath. In its refusal to provide abortion counseling and referral in its pre-pregnancy family planning, the Government is con-

⁴⁷ For a fuller refutation of the First Amendment challenge, see *Brief of the American Academy of Medical Ethics as Amicus Curiae in Support of Respondent*.

sistent with centuries of medical practice and ethics. To embrace Petitioners' argument would require this Court to expand *Roe* in an unwarranted fashion deleterious to American medicine, to the health of pregnant women and their children, and to the Government's well-established right to advance its policies through allocation of its resources.

CONCLUSION

The judgment of the U.S. Court of Appeals for the Second Circuit should be affirmed.

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** Counsel for *Amicus Curiae* would like to acknowledge the significant research assistance of Peter Poon (J.D., Berkeley, 1992) in the preparation of this Brief.

APPENDICES

APPENDIX A

42 C.F.R. § 59.1-59.10 (1989)

**Part 59—GRANTS FOR FAMILY
PLANNING SERVICES**

* * *

**SUBPART A—PROJECT GRANTS FOR FAMILY
PLANNING SERVICES**

Sec. 59.1 To what programs do these regulations apply?

The regulations of this subpart are applicable to the award of grants under section 1001 of the Public Health Service Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects. These projects shall consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children.

Sec. 59.2 Definitions.

As used in this subpart:

“Act” means a social unit composed of one person, or two or more persons living together, as a household.

“Family” means a social unit composed of one person, or two or more persons living together, as a household.

“Family planning” means the process of establishing objectives for the number and spacing of one’s children and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods (including natural family planning and abstinence) and the management of infertility (including adoption). Family planning services includes preconceptional counseling, education, and general reproductive health care (includ-

ing diagnosis and treatment of infections which threaten reproductive capability). Family planning does not include pregnancy care (including obstetric or prenatal care). As required by section 1008 of the Act, abortion may not be included as a method of family planning in the Title X project. Family planning, as supported under this subpart, should reduce the incidence of abortion.

"Grantee" means the organization to which a grant is awarded under section 1001 of the Act.

"Low-income family" means a family whose total annual income does not exceed 100 percent of the most recent Community Services Administration Income Poverty Guidelines (45 CFR 1060.2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the Title X project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources.

"Nonprofit," as applied to any private agency, institution, or organization, means that no part of the entity's net earnings benefit, or may lawfully benefit, any private shareholder or individual.

"Prenatal care" means medical services provided to a pregnant woman to promote maternal and fetal health.

"Program" and "project" are used interchangeably and mean a coherent assembly of plans, activities and supporting resources contained within an administrative framework.

"Secretary" means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

"State" means one of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, Northern Marianas, or the Trust Territory of the Pacific Islands.

"Title X" means Title X of the Act, 42 U.S.C., 300, et seq.

"Title X program" and Title X project" are used interchangeably and mean the identified program which is approved by the Secretary for support under section 1001 of the Act, as the context may require. Title X project funds include all funds allocated to the Title X program, including but not limited to grant funds, grant-related income or matching funds.

Sec. 59.3 Who is eligible to apply for a family planning services grant?

Any public or nonprofit private entity in a State may apply for a grant under this subpart.

Sec. 59.4 How does one apply for a family planning services grant?

(a) Application for a grant under this subpart shall be made on an authorized form.

(b) An individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain—

(1) A description satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

Sec. 59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents). If an organization offers only a single method of family planning, such as natural family planning, it may participate as part of a Title X project as long as the entire Title X project offers a broad range of family planning services.

2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant.

(3) Provide services in a manner which protects the dignity of the individual.

(4) Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

(5) Provide that priority in the provision of services will be given to persons from low-income families.

(6) Provide that no charge will be made for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a Government agency) which is authorized to or is under legal obligation to pay this charge.

(7) Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent CSA Income Poverty Guidelines (45 CFR 1060.2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

(8) If a third party (including a Government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX or title XX of the Social Security Act, a written agreement with the title XIX or title XX agency is required.

(9) (i) Provide that if an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential subgrantees which have previously provided or propose to provide family planning services to the area proposed to be served by the applicant.

(ii) Provide an opportunity for maximum participation by existing or potential sub-

grantees in the ongoing policy decisionmaking of the project.

(10) Provide for an Advisory Committee as required by Sec. 59.6.

(b) In addition to the requirements of paragraph (a) of this section, each Title X project must meet each of the following requirements unless the Secretary determines that the Title X project has established good cause for its omission. Each Title X project must:

(1) Provide for medical services related to family planning (including physician's consultation, examination prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for informational and educational programs designed to (i) achieve community understanding of the objectives of the Title X program, (ii) inform the community of the availability of services, and (iii) promote continued participation in the Title X project by persons to whom family planning services may be beneficial.

(4) Provide for orientation and in-service training for all Title X project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by the physician.

(6) Provide that family planning medical services will be performed under the direction of a physician

with special training or experience in family planning.

(7) Provide that all services purchased for the Title X project participants will be authorized by the Title X project director or his designee on the Title X project staff.

(8) Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services will be provided in accordance with a plan which establishes rates and methods of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the Title X project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

Sec. 59.6 [Omitted]

Sec. 59.7 Standards of compliance with prohibition on abortion.

A project may not receive funds under this subpart unless it provides assurance satisfactory to the Secretary that it does not include abortion as a method of

family planning. Such assurance must include, as a minimum, representations (supported by such documentation as the Secretary may request) as to compliance with each of the requirements in Sec. 59.8 through Sec. 59.10. A project must comply with such requirements at all times during the period for which support under Title X is provided.

Sec. 59.8 Prohibition on counseling and referral for abortion services; limitation of program services to family planning.

(a) (1) A Title X project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning.

(2) Because Title X funds are intended only for family planning, once a client served by a Title X project is diagnosed as pregnant, she must be referred for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of mother and unborn child. She must also be provided with information necessary to protect the health of mother and unborn child until such time as the referral appointment is kept. In cases in which emergency care is required, however, the Title X project shall be required only to refer the client immediately to an appropriate provider of emergency medical services.

(3) A Title X project may not use prenatal, social service or emergency medical or other referrals as an indirect means of encouraging or promoting abortion as a method of family planning, such as by weighing the list of referrals in favor of health care providers which perform abortions, by including on the list of referral providers health care providers whose principal business is the provision of abortion, by excluding available providers who do not

provide abortions, or by "steering" clients to providers who offer abortion as a method of family planning.

(4) Nothing in this subpart shall be construed as prohibiting the provision of information to a project client which is medically necessary to assess the risks and benefits of different methods of contraception in the course of selecting a method; provided, that the provision of this information does not include counseling with respect to or otherwise promote abortion as a method of family planning.

(b) Examples.

(1) A pregnant client of a Title X project requests prenatal care services, which project personnel are qualified to provide. Because the provision of such services is outside the scope of family planning supported by Title X, the client must be referred to appropriate providers of prenatal care.

(2) A Title X project discovers an ectopic pregnancy in the course of conducting a physical examination of a client. Referral arrangements for emergency medical care are immediately provided. Such action is in compliance with the requirements of paragraph (a) (2) of this section.

(3) A pregnant woman asks the Title X project to provide her with a list of abortion providers in the area. The Title X project tells her that it does not refer for abortion but provides her a list which includes, among other health care providers, a local clinic which principally provides abortions. Inclusion of the clinic on the list is inconsistent with paragraph (a) (3) of this section.

(4) A pregnant woman asks the Title X project to provide her with a list of abortion providers in the area. The project tells her that it does not refer

for abortion and provides her a list which consists of hospitals and clinics and other providers which provide prenatal care and also provide abortions. None of the entries on the list are providers that principally provide abortions. Although there are several appropriate providers of prenatal care in the area which do not provide or refer for abortions, none of these providers are included on the list. Provision of the list is inconsistent with paragraph (a) (3) of this section.

(5) A pregnant woman requests information on abortion and asks the Title X project to refer her to an abortion provider. The project counselor tells her that the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion. The counselor further tells the client that the project can help her to obtain prenatal care and necessary social services, and provides her with a list of such providers from which the client may choose. Such actions are consistent with paragraph (a) of this section.

(6) Title X project staff provide contraceptive counseling to a client in order to assist her in selecting a contraceptive method. In discussing oral contraceptives, the project counselor provides the client with information contained in the patient package insert accompanying a brand of oral contraceptives, referring to abortion only in the context of a discussion of the relative safety of various contraceptive methods and in no way promoting abortion as a method of family planning. The provisions of this information does not constitute abortion counseling or referral.

Sec. 59.9 Maintenance of program integrity.

A Title X project must be organized so that it is physically and financially separate, as determined in

accordance with the review established in this section, from activities which are prohibited under section 1008 of the Act and Sec. 59.8 and Sec. 59.10 of these regulations from inclusion in the Title X program. In order to be physically and financially separate, a Title X project must have an objective integrity and independence from prohibited activities. Mere bookkeeping separation of Title X funds from other monies is not sufficient. The Secretary will determine whether such objective integrity and independence exist based on a review of facts and circumstances. Factors relevant to this determination shall include (but are not limited to):

- (a) The existence of separate accounting records;
- (b) The degree of separation from facilities (e.g., treatment, consultation, examination, and waiting rooms) in which prohibited activities occur and the extent of such prohibited activities;
- (c) The existence of separate personnel;
- (d) The extent to which signs and other forms of identification of the Title X project are present and signs and material promoting abortion are absent.

Sec. 59.10 Prohibition on activities that encourage, promote or advocate abortion.

(a) A Title X project may not encourage, promote or advocate abortion as a method of family planning. This requirement prohibits actions to assist women to obtain abortions or increase the availability or accessibility of abortion for family planning purposes. Prohibited actions include the use of Title X project funds for the following:

- (1) Lobbying for the passage of legislation to increase in any way the availability of abortion as a method of family planning;

(2) Providing speakers to promote the use of abortion as a method of family planning;

(3) Paying dues to any group that as a significant part of its activities advocates abortion as a method of family planning;

(4) Using legal action to make abortion available in any way as a method of family planning; and

(5) Developing or disseminating in any way materials (including printed matter and audiovisual materials) advocating abortion as a method of family planning.

(b) Examples.

(1) Clients at the Title X project are given brochures advertising an abortion clinic. The Title X project has violated paragraph (a) of this section.

(2) A Title X project makes an appointment for a pregnant client with an abortion clinic. The Title X project has violated paragraph (a) of this section.

(3) A Title X project pays dues to a state association which, among other activities, lobbies at state and local levels for the passage of legislation to protect and expand the legal availability of abortion as a method of family planning. The association spends a significant amount of its annual budget on such activity. Payment of dues to the association violates paragraph (a) (3) of this section.

(4) An organization conducts a number of activities, including operating a Title X project. The organization uses non-project funds to pay dues to an association which, among other activities, engages in lobbying to protect and expand the legal availability of abortion as a method of family planning. The association spends a significant amount of its annual budget on such activity. Payment of dues to the association by the organization does not violate paragraph (a) (3) of this section.

(5) An organization that operates a Title X project engages in lobbying to increase the legal availability of abortion as a method of family planning. The project itself engages in no such activities and the facilities and funds of the project are kept separate from prohibited activities. The project is not in violation of paragraph (a) (1) of this section.

(6) Employees of a Title X project write their legislative representatives in support of legislation seeking to expand the legal availability of abortion, using no project funds to do so. The Title X project has not violated paragraph (a) (1) of this section.

(7) On her own time and at her own expense, a Title X project employee speaks before a legislative body in support of abortion as a method of family planning. The Title X project has not violated paragraph (a) of this section.

Sec. 59.11 [Omitted]

Sec. 59.12 [Omitted]

Sec. 59.13 [Omitted]

Sec. 59.14 [Omitted]

Sec. 59.15 [Omitted]

Sec. 59.16 [Omitted]

Sec. 59.17 [Omitted]

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 88-0701, 88-0702

Judge Louis L. Stanton

STATE OF NEW YORK, *et al.*,
*Plaintiffs,*IRVING RUST, *et al.*,
Plaintiffs,

v.

OTIS R. BOWEN,
*Defendant.*AFFIDAVIT OF RICHARD T. F. SCHMIDT,
M.D., FACOG

Affiant states as follows:

1. I am Richard T. F. Schmidt, M.D., a Fellow of the American College of Obstetricians and Gynecologists, clinical Professor of Obstetrics/Gynecology at the University of Cincinnati, and Director Emeritus of the Department of Obstetrics/Gynecology, Good Samaritan Hospital, a university-affiliated hospital which provides the largest maternity service in the State of Ohio, a Level III high risk perinatal unit and, among other allied services, a Teen Parent program, which I initially founded with the aid of federal funds.

2. For over 35 years, I have been actively involved in the clinical practice of obstetrics and gynecology and

over a major portion of this time, have held a variety of national policy-making positions. I served as President of the American College of Obstetricians and Gynecologists (ACOG) (1977-78), after a six-year term on its Executive Board and Executive Committee. I edited a previous edition of the College's definitive policy publication, *Standards for Obstetric-Gynecologic Services*. I served on the College's Health Care Commission and, among many committee assignments, served on its Committee on Bioethics.

3. In recent years, I have served two terms on the Council on Scientific Affairs of the American Medical Association (AMA). I am currently a member of the Steering Committee of the Health Policy Agenda for the American People and chaired one of the six working groups (Work Group 1, Medical Science) which prepared the material that ultimately constituted the report of this three-year effort which brought together a broad cross-section of the public and private agencies and organizations concerned with the funding and delivery of health care throughout the nation.

4. I submit this statement in *support* of the new rules (53 Fed. Reg. 2922 (February 2, 1988)) because of the considered judgment that:

(1) a change in rule is necessary if the obvious intent of Congress to separate the promotion and provision of abortion services from the public funding of family planning programs is to be fulfilled;

(2) the changes are fully compatible with the real-world operation of family planning programs, as opposed to the provision of abortion services;

(3) the change will not impair, or even significantly alter, the provision of family planning or prenatal services as differentiated from the promotion or provision of abortion services.

5. The need for a change in rule has been repeatedly demonstrated to me first hand by both private patients and patients in the Teen Parent program which we founded to meet the needs of those young pregnant women who did not choose abortion. The story was so common that it was almost routine: When a pregnancy was diagnosed in some Title X programs it was presumed that because the patient wanted to avoid pregnancy she would necessarily and appropriately wish to avoid childbirth and therefore *should* want to be aborted. Alternatives to abortion were either not offered spontaneously or were presented in such a way as to convey the message that such alternatives were not very good judgment. Repeatedly, patients described an uphill struggle to get help in their dilemma that did not presume abortion as the only reasonable solution. My own conclusion was not so much that the counselors were overtly limiting the patients' choices, but rather that their own judgments were being transferred, consciously or unconsciously, to the patient. For this reason, I believe that objective guidelines to avoid this conscious or unconscious bias toward abortion are necessary to fulfill the intent of Congress.

6. I am unaware of the allegation that the change in rule will seriously impair the delivery of *prenatal* care. It should be emphasized that family planning clinics do not normally provide prenatal care even though a family planning clinic may be associated with, or housed in the same facility as, a prenatal clinic. The normal procedure is to *refer* those patients requiring or desiring prenatal care to a prenatal clinic which is staffed or equipped for such care. The obvious reason is that the need for these functions are quite different. The volume and flow of patients in the average family planning clinic is such that a great portion of this service can appropriately be supplied by allied health care people under the supervision of a physician. Prenatal care, however, particularly when it involves medical judgment, requires

more time per patient and a substantially larger and more immediate component of physician involvement. As I read the new rule, it simply requires what is already being done, except that such referral be made in a non-judgmental way.

7. I am also aware that it is asserted that the new rule would prevent the physician from providing full information to the patient regarding her options. I would ask "Full information about what?" The issue is the provision of family planning services. Had Congress, in this specific law, intended to fund a full range of perinatal services, including prenatal care and abortion, I am sure that it would have said so. In fact, it specifically excluded other such services. The only contexts in which this assertion would be valid would be the belief that abortion is an appropriate part of family planning; or, that prenatal services including abortion are inseparable from family planning. Were this latter position held, it would seem that either Congress would have to reword the law or the holders of this position would have to forego these Title X funds.

8. As a matter of practical fact, as I have pointed out above, the separation of family planning from other perinatal services is normally and customarily made for very mundane and practical reasons.

9. Moreover, I would suggest that if complicated medical issues are involved, such as the management of the pregnant woman seropositive for AIDS, to cite one example proposed, then this counseling and decisionmaking should appropriately take place in a perinatal clinic or facility organized, equipped, and staffed for a full range of diagnostic and treatment services rather than in the faster-paced, more focused atmosphere of the family planning clinic.

10. For these reasons, I believe that the change in rule is not only warranted but fully compatible with the effective operation of family planning facilities.

FURTHER AFFLIANT SAITH NOT.

Richard T.F. Schmidt
 RICHARD T.F. SCHMIDT, M.D.
 FACOG

Subscribed and Sworn to before me
 this — day of February, 1988.

Notary Public

APPENDIX C

STATE INFORMED CONSENT STATUTES

Alaska Stat. 09.55.556 (1989); Ariz. Rev. Stat. Ann. 12-563 (1982); Ark. Stat. Ann. 16-114-206 (1987); Cal. Penal Code 2670.5-2674 (West 1982) (prisoners' right to give informed consent to organic therapy); Colo. Rev. Stat. 13-20-401, -402 (1987) (written informed consent needed for electro-convulsive treatments); Del. Code Ann. tit. 18, 6852 (1989); Fla. Stat. Ann. 766.103 (West Supp. 1990); Ga. Code Ann. 31-9-6.1 (1985); Haw. Rev. Stat. 671-3 (1985); Idaho Code 39-4301-4306 (1985); Iowa Code Ann. 147.137 (West 1989); Ky. Rev. Stat. Ann. 304.40-.320 (Baldwin (1987); La. Rev. Stat. Ann. 40:1299.40 (West 1977); Me. Rev. Stat. Ann. tit. 24, 2905 (Supp. 1989-90); Mass. Gen. Laws Ann. ch. 111, 70E (West 1983) (health care patients "have the right . . . to informed consent to the extent provided by law"); Mich. Comp. Laws Ann. 33.20201 (West 1980) (health care patients' right to give informed consent to treatment); Minn. Stat. Ann. 144.651 (West 1989) (health care patients' right to give informed consent to treatment); Mo. Ann. Stat. 198.088 (Vernon 1983) (nursing home patients' right to give informed consent to experimental treatment); Neb. Rev. Stat. 44-2816 (1988); Nev. Rev. Stat. 41A.110 (1987); Nev. Rev. Stat. 449.710 (health care patients' right to give informed consent to treatment) (1987); N.H. Rev. Stat. Ann. 507-C:1, -C:2 (1989); N.Y. Pub. Health Law 2805-d (McKinney 1985); N.Y. Pub. Health Law 2440-2446 (McKinney 1985) (right to give informed consent to experimental treatment); N.C. Gen. Stat. 90-21.13 (1985); Ohio Rev. Code Ann. 2317.54 (Anderson 1981); Or. Rev. Stat. 677.097 (1989); Or. Rev. Stat. 441.605 (1989) (nursing home patients' right to give informed consent to treatment); Pa. Cons. Stat. Ann. tit. 40, 1301.103 (Purdon Supp. 1990-91); Tenn. Code Ann. 29-26-118 (1980); Tex.

Rev. Civ. Stat. Ann. art. 4590i, 6.01-.07 (Vernon Supp. 1989-90); Utah Code Ann. 78-14-5 (1987); Vt. Stat. Ann. tit. 12, sec. 1909 (Supp. 1989-90); Va. Code Ann. 37.1-234, -235 (Supp. 1989) (informed consent must be obtained in order to conduct human research); Wash. Rev. Code Ann. 7.70.050, 7.70-060 (Supp. 1989-90).

APPENDIX D

STATE CONSCIENCE STATUTES

Alas. Stat. 18.16.010(b) (1986); Ariz. Stat. Ann. 36-2151 (1986); Ark. Code Ann. 20-16-601 (1987); Cal. Health & Safety Code Ann. 25955 (West 1984); Colo. Rev. Stat. 18-6-104 (1986); Del. Code Ann. tit. 24, 1791 (1987); Fla. Stat. Ann. 390.001(8) (1986); Ga. Code Ann. 26-1202(e) (1983); Haw. Rev. Stat. 453-16(d) (1985); Idaho Code 18-612 (1987); Ill. Rev. Stat. ch. 38, 8-33 (1989); Burns Ind. Stat. Ann. 16-10-3 (1990); Iowa Code Ann. 146.1 (West 1989); Kan. Stat. Ann. 65-443 (1985); Ky. Rev. Stat. 311.800 (Supp. 1990); La. Rev. Stat. Ann. 40:1299.31 (West 1977); Me. Rev. Stat. Ann. tit. 22, 1591 (1980); Ann. Code Md. Health-Gen. 20-214 (1990); Ann. Laws Mass. ch. 112, sec. 12I (1985); Mich. Comp. Laws Ann. sec. 14.15(2018) (1980); Minn. Stat. Ann. 145:414, 145.42 (1989); Mo. Ann. Stat. 197.032 (Vernon 1983); Mont. Code Ann. 50-20-111 (1989); Neb. Rev. Stat. 28-338 (1985); Nev. Rev. Stat. 632.475, 449.191 (1987); N.J. Stat. Ann. 2A:65A-1 (West 1987); N.M. Stat. Ann. 30-5-2 (1984); N.Y. Civ. Rights Law 79-i (McKinney 1976); N.C. Gen. Stat. 14-45.1(e) (1986); N.D. Cent. Code 23-16-14 (1978); Ohio Rev. Code Ann. 4731.91 (Page Supp. 1989); Okla. Stat. Ann. tit. 63, 1-741 (West 1984); Or. Rev. Stat. 435.485 (1987); Pa. Stat. Ann. tit. 43, 955.2 (Purdon Supp. 1990); R.I. Gen. Laws 23-17-11 (1989); S.C. Code 44-41-50 (1985); S.D. Codified Laws Ann. 34-23A-12 (1986); Tenn. Code Ann. 39-4-204 (1982); Tex. Rev. Civ. Stat. art. 4512-7 (Vernon Supp. 1990); Utah Code Ann. 76-7-306 (1990); Va. Code 18.2-75 (1988); Wash. Rev. Code Ann. 9.02.080 (1988); Wis. Stat. Ann. 140.42, 441.06(6) (West 1989); Wyo. Stat. 35-6-106 (1988).